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CLINICAL LECTURE.

THE URETHROTOMIES.*

REGINALD HARRISON, F.R.C.S.

LONDON.

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UNDER the title of the urethrotomies I propose taking a review of their application to some diseases and injuries of the male urinary organs.

It will be convenient to consider in the first place those specially applicable to stricture, namely: (1) Internal urethrotomy; (2) external urethrotomy, otherwise called perineal section, and (3) the combination of these two proceedings.

It is hardly necessary to point out the serious effects that are liable to follow any permanent obstruction to the discharge of urine along the urethra. In this way may be brought about all degrees of disorganization of the urinary apparatus from the kidneys downwards as well as various local effects about the seat of stricture which include inflammation, suppuration, extravasation of urine and mortification. These consequences will be found illustrated and described in various works on pathology, to which reference should be made.

It will however, be remarked that included in the inflammatory processes may be recognized means by which nature provides a way of liberating urine that is suddenly extravasated and imprisoned. It is well known that there is no animal fluid so destructive to normal tissues as urine charged with ammonia by the decomposition of urea.

Though these effects by their violence are not infrequently in themselves fatal they have occasionally by mortification liberated pent-up urine saturated with ammonia and so proved the means of saving life, though at the cost of much suffering and permanent damage to the parts, which by timely surgical aid might have been prevented. This urea may be said figuratively, to furnish the dynamite for this purpose.

I think that urea has justified its existence as a natural constituent of the urine by providing for a contingency in connection with obstructed micturition which has proved occasionally of no little service.

I have met with several instances of persons who, in places far beyond the reach of surgical aid, have suffered from extravasation of urine and sloughing whose lives were undoubtedly saved in this way. Further I have recorded a case† where apparently by the absence of urea extravasated urine was rendered chemically harmless to the tissues which confined it.

INTERNAL URETHROTOMY.

In looking back at surgical opinion and practice which prevailed about the time prior to the general adoption of antiseptics it could hardly be said that this operation was favorably regarded, though numberless instruments were devised for this purpose, and some important observations were made on the subject.

Amongst the latter I would include the almost forgotten work of the late Dr. Fessenden Otis, of New York, who demonstrated the larger dimensions of the male urethra, and thus exercised not only a marked influence on the treatment of stricture, but led up to the great improvements that followed in connection with the removal of stone from the bladder by Dr. Bigelow of Boston.

Notwithstanding the various communications which were made on the subject of in-

*This is No. 1 of a series of lectures on this subject, delivered at the London Post-Graduate College. To follow: (2) Internal and External Urethrotomy. (3) The Conbination of External and Internal Urethrotomy.

†Surgical Disorders of the Urinary Organs. Fourth Ed. p. 133.

ternal urethrotomy at the time referred to, by far the larger number of strictures were almost indiscriminately treated by some form of dilatation with bougies, whilst in the minority of these cases the selection of a more radical operation was largely determined by the mechanical impossibility of proceeding to carry out the former treatment.

The objections which were then urged against a more general adoption of urethrotomy were chiefly: The frequency with which this operation was followed by paroxysms of urethral or urinary fever attended with rigors. Teevan stated in treating of this subject that two-thirds of the cases thus operated on suffered in this way and in a much larger proportion than where dilatation was alone practiced; that greater risk was incurred; and lastly, on the ground that urethrotomy did not prevent a recurrence of the contraction or dispose of the necessity for the occasional use of a bougie subsequently as a preventive of relapse. In the light of more recent developments having a direct reference to the general recognition of antiseptics I will refer to these several considerations.

URETHRAL FEVER.

In the pre-antispetic days the rigors and fever which not uncommonly followed surgical interference with the urethra however slight or transient it might be, were almost universally regarded as of a neurotic origin, or as due to shock propagated by the sympathetic nervous system. It has always seemed to me that there was little or no support for this explanation.

There is no analogous example connected with other injuries or lesions of the body. The rigors and fever which follow and may reasonably be expected after an internal urethrotomy are conspicuous by their absence where in addition to the urethrotomy a perineal cystotomy is provided for efficient drainage.

Further, some experiments in sterilizing, or rather adulterating the urine as will presently be referred to, are directly opposed to the neurotic hypothesis.

The only evidence of shock propagated by the sympathetic nervous system I can recall in connection with surgical lesions of the genito-urinary apparatus is distinctly at variance with such a theory.

I refer to the shock which in some degree is obvious both to the operating surgeon and to the anesthetist, who are both interested in the phenomenon, when, for the removal of a testis, the spermatic cord is ligatured and divided. Here heart and breathing often indicate this. I do not think it necessary to pursue this argument further.

One of the earliest communications in reference to the nature and prevention of urinary fever as a sequence of surgical interference with the urethra was by Dr. Palmer, of Louisville, U. S.A., in 1867. He showed by a long series of cases that by sterilizing the urine beforehand with boracic acid given by the mouth the liability to urinary fever after passing catheters and bougies or causing any lesions of the urethra, was greatly diminished.

Dr. Palmer's results in reference to the sterilization or adulteration of the urine with certain drugs led me to make some observations on more direct means of influencing the excretion.

For some years past I have made a habit in cases of operation on the male urethra such as internal urethrotomy, or where there is reason to believe that the canal has been abraded or actually wounded by the passage along of catheters, bougies or sounds, of filling the bladder with a solution of boric acid and asking the patient to retain it for some time.

Thus the first urine that is voluntarily passed after what may have been done operatively is not only a diluted specimen of the excretion, but is charged with an antiseptic solution. It should be remembered that the earlier rigors occurring after these lesions are those which are sometimes premonitory of the more serious symptoms that may follow, such as suppression. In the few fatal cases I have seen of the latter, after interference with the urethra, the first rigor happened within a few hours. The rigors and fever which occur after an interval of twenty-four hours or so following the use of an instrument I have not thought of any moment.

Since adopting this practice generally I have found the occurrence of urinary fever much less common than formerly, and when it happened correspondingly less important. For this purpose injections of boric acid solution seemed more potent than those containing mercuric preparations.

Where a catheter is retained for some days, as after internal urethrotomy, and the escape of urine is controlled by a plug or tap at the orifice of the instrument, I have succeeded by repeating these injections into the bladder, of averting these intermittent febrile attacks.

THE RESULTS OF INTERNAL URETHROTOMY RELATIVE TO ITS SELECTION.

In dealing with the urethrotomies it is not to be presumed that I undervalue the methods of treating strictures by various forms of dilatation with bougies. On the contrary, there can be no doubt (except perhaps, with some of the traumatic varieties resulting from

ruptures of the urethra) that all strictures of an inflammatory origin have a place or preliminary stage of various duration. A period when so to speak they may be moulded by the hand and instrument of the surgeon or educated patient, as the potter moulds clay while it is impressive.

When, however, this stage has been allowed to pass by and the obstruction not only distorts or alters the urine stream, but assumes the characteristics of an increasingly contractile scar, section and the introduction of what I shall again refer to descriptively as a splice or interval of new tissue becomes a necessity.

All strictures are liable to change as age advances and to undergo fibrous degeneration. In this way even after years of careful attention they may become india-rubber-like and resist treatment which hitherto had been carried on with success. It may then be necessary to substitute division for dilatation.

In determining the time and stage when this substitution should take place "the whip" or graduated bougies* I described many years ago, and which are now much used for treating strictures will be found reliable indicators.

Some perhaps have never heard of these flexible instruments, yet I think most surgeons will on trial find them a useful additio to their armementarium. They are particularly serviceable in commencing the treatment of strictures which are difficult to enter. In advising an internal urethrotomy as a substitute for dilatation I think the following paragraphs taken from the Annual Surgical Reports of St. Peter's Hospital, London, indicate the favorable opinions that have been formed of this operaton in recent years:

"One hundred and thirty-six cases of urethral stricture were admitted (1903) of which 92 were operated upon by internal urethrotomy with one death from acute suppression thirty-six hours after the operation; and 119 cases of stricture were admitted (1904), of these 90 were operated upon by internal urethotomy with no deaths.

This gives a total of 255 cases of stricture in two consecutive years, of which 182 were operated upon in this way with one death, whilst cases were treated by dilatation and in other ways."

Satisfactory as these figures are it has been said, "once strictured, always strictured." By this is implied that however successful treatment may be, recurrence is liable to take place.

In the course of these remarks I shall endeavor to show that this liability may be considerably lessened by giving effect to certain principles of treatment having special reference to injury and repair as uniquely observed in connection with some lesions of the urinary apparatus, and which hitherto have not received due consideration.

To this aspect of the subjects have devoted considerable attention. In 1900 I prepared, by request, a report for the International Medical Congress at Paris on the remote effects of structural lesions (interventions sangulantes) in urethro-stenosis. This entailed a very full investigation, and many persons were examined who had undergone operations for stricture at varying intervals previously.

The conclusions I arrived at were that the normal calibre of the urethra might be completely and permanently restored, and that the absence of recurrence, as demonstrated by many cases which were carefully investigated, was not necessarily dependent on the use of a bougie after operation. In several cases, such as those I am referring to later on, recurrence was due not so much to the original stricture, but to a general sclerosis which the entire length of the urethra had undergone.

*The Lancet, Feb. 3, 1883.

THE term "doctor" was invented in the twelfth century, about the time of the first establishment of universities. The first person upon whom this title was conferred was Irnerius, a professor of law at Bologna University. The title was created by Emperor Lohaire II, but was suggested by Irnerius himself. The term extended to the faculty of theology, and was first given by the University of Paris to Peter Lombard, the famous theologian. In 1329 the College of Asti conferred the first title of doctor of medicine upon William Gordenio.

COSTAL OR RIB-BREATHING.—Costal or rib-breathing is the most efficient. It enables the singer and the speaker to take in the greatest amount of breath, and the effort is not great because it is shared by all those muscles whose function it is to pull the ribs upward and outward. If the thorax is unconstricted, the greatest expansion will be about its lower and middle portions where the ribs are more movable and where the angle of their inclination with the spine is most acute. Another reason why this type of breathing is the most effective in that this uplifting of the ribs puts the thorax into the best possible position for the expiratory control that follows during the act of vocalization. The diaphragm for artistic purposes is not an inspiratory muscle; it should be used only in the expiratory effort of singing and speaking.

LEADING ARTICLES

DIAGNOSIS OF PYLORIC STENOSIS.

EDWIN WALKER, M. D.

EVANSVILLE, IND.

ACCURATE knowledge of the pathology, diagnosis and treatment of diseases of the stomach is of very recent origin. The last twenty-five years have contributed more useful information than all the time preceding. It is true that Kussmaul gave us the stomach-tube in 1869, and in 1871 Leube pointed out its importance as a means of diagnosis and made some valuable contributions to our knowledge of the motility and secretions of the stomach. In the early eighties, Ewald, Boaz and Riegal studied further the secretions of the stomach and many other workers joined them and gradually a fairly good knowledge of the chemistry of the gastric juices was formulated. But so many were the methods and so extensive was the literature in this mass of information. It has been so difficult to get distinctly the essential points and contradictory statements have kept the profession from employing methods which were useful.

The surgeon came to our aid about the same time; before 1880 few operations had been done. During the five years following, Billroth, Czerny and Peau had proven that surgery was worth investigation and from that time a large number of operations were done by many operators. The mortality of the reported cases was high, and doubtless had all been reported, it would have been very much higher, but notwithstanding this, real progress was made, not only in technique but in pathology, as well. By the united efforts of the internist and surgeon, we are slowly clearing the way to a better understanding of the indications and limitations of surgical interference. Still at this time the conscientious practitioner finds great difficulty in discerning the truth, for the vast amount of literature is confusing, and it seems to me that indications laid down by most surgeons are not altogether reliable or safe, and are too often vague and unsatisfactory. For example, we are directed to make an exploratory incision in "chronic stomach troubles" which have resisted treatment for some months or years. Such directions are entirely too indefinite for they would include many functional cases. I admit that an accurate diagnosis is not always possible, but it is so in a very large proportion of cases, the failure being rare exceptions. I think, too, that exploratory incisions have been given too much prominence; it sounds plausible and so easy to say, "if you cannot find the exact condition, open the abdomen and see exactly what the trouble is." It must not be forgotten that it is difficult through the ordinary opening in the abdomen to fully explore all parts of the stomach and ulcers and gross lesions are often overlooked. On the other hand, by careful study of the clinical history, supplemented by modern methods of physical examination, we will be able, in most cases, to accurately diagnose the condition, and in some of them, better than we could by an exploratory incision.

I would say, in chronic organic stomach diseases, in which stenosis of the pylorus exists, or in cases of chronic ulcers, which have resisted rational treatment, and also in cancer of the pylorus, where the patient is in fairly good condition, an exploratory incision is indicated. There probably would still be a few other chronic organic cases in which it would be justifiable, but there would not be many. This would leave a comparatively small number of cases which would require an exploratory incision, and I venture to predict that with the increased knowledge of diseases of the stomach, the indications for operative interference will be greatly curtailed and the number of operations much smaller, but the results, both as to mortality and benefit of the patient, will be better than at present.

Some authors speak of operations for ulcers in a way to leave the impression that is indicated in a very large proportion of cases, while I know of no recent statistics on which to base a conclusion; from my own limited observations I think the percentum would be below ten. The older statistics of the cure of ulcer by dietetic and medical treatment are not to be relied upon, more recent results being much more favorable. Operations for cancer are far from satisfactory; resections are almost without exception a total failure, and conservative operations offer at best only temporary improvement, and few subjects live more than one year. Cancer of the lesser curvature represents 80 per cent of all cases, and surgery can do nothing for them. At the pyloric end, the condition is more favorable both as to early diagnosis and operation, but operations, so far, have done but little permanent good.

I wish, therefore, today to direct your attention to pyloric stenosis for this is the condition in which an operation may do good. The benign ones furnish our most satisfactory cases and of the malignant ones, while far from promising, by early work we may be rewarded by a small measure of success.

We must first determine that stenosis of the pylorus exists, then the lesson which causes it.

Let us briefly enumerate the cases. We have temporary stenosis from inflammatory swelling in acute gastritis; this is usually easily determined from the symptoms and the transitory character and need not concern us at this time. A foreign body may become lodged in the pylorus. The latter will normally allow a silver dollar to pass (Cohnheim). Collections of hair and gall-stones, as well as polypus of the stomach have also caused obstruction. An ulcer with thickened walls often causes stenosis; in some of these cases a tumor is distinctly palpable. Small ulcers, by inducing spasm of the pylorus, may also cause stenosis, likewise a cicatrix of a healed ulcer. The latter contracts, gradually narrowing the orifice and often years pass before symptoms indicate the condition. A tumor external to the stomach and adhesions may compress, and thus narrow or occlude the pylorus. Also, in gastroptosis, acute kinking of the stomach and the duodenum may also cause stenosis. These are the causes in the benign cases, and the malignant ones are, with rare exceptions, carcinoma. Ulcer, or the cicatrix following and carcinoma are the causes in almost all cases.

Now, how are we to diagnose stenosis? This depends on the establishment of two conditions, stagnation and gastrecasia. By stagnation we mean that the stomach does not empty itself in seven or eight hours. Much has been written about atony as a cause of stagnation, and I am not prepared to say it does not do so in rare cases, but I do say that when you find stagnation, in almost all cases, you have a stenosis of the pylorus. If, therefore, you find in the stomach in the morning, food which was taken the evening before, you are practically certain that there is an obstruction at the pylorus.

If, in addition to this, you find the stomach dilated, the diagnosis of stenosis is complete. Let me here direct your attention to a few points too often overlooked. If you find the greater curvature below the umbilicus, it does not follow that you have dilatation; it may mean that the normal position of the stomach is more nearly vertical. This is true in those who have the "habitus enteroptoticus" first pointed out by Stillen. This he used to designate those individuals who had an acute costal angle, and the distance from the umbilicus to the ensiform cartilage was greater than from the middle line to the anterior axillary line, and also a floating tenth rib. Such individuals are usually under-nourished, and are prone to displacement of viscera, including stomach, liver, kidney and uterus, and they, as a rule, suffer from functional diseases. On the other hand, those who have the normal habitus, viz., a broad costal angle, the distance from the umbilicus to the ensiform is less than the distance from the middle line to the anterior auxillary line, seldom suffer with functional diseases, but are the victims of organic disease. If, therefore, you find the greater curvature below the umbilicus, and the patient presents the "habitus enteroptoticus," the probability is that gastresctasia does not exist. In fact, we cannot say a patient has dilatation until we demonstrate that stagnation exists. The stomach is like the heart, when there is obstruction to the outflow, the muscular wall hypertrophies and furnishes the necessary force to empty the organ, and when the obstruction becomes so great that the power of the muscle is insufficient, the organ dilates. The stomach, like the heart, dilates when muscular insufficiency exists. So long, then, as the stomach is able to overcome the obstruction, neither gastrectasia or stagnation are found, even if the pylorus is narrowed.

In these cases if the passage of food through the pylorus is markedly compromised, the quantity of urine decreases, and when the total quantity for twenty-four hours falls below 500 cc. (one pint), and this is not increased by proper diet, it is an indication that operative interference offers the only hope of relief (Cohnheim).

When we have established the existence of pyloric stenosis we must determine whether the lesion causing it is benign or malignant. This is done in part by the history, but more surely by the examination of the secretions. Benign cases are of longer duration, do not so markedly affect the general health, and while great emaciation may exist, there is no cachexia. The benign cases also usually give history of ulcer, or some acute inflammatory disease or of some lesion outside of the stomach. The malignant cases are attended by more rapid emaciation, cachexia, pain, vomiting of blood and mucus, and the development of tumor. The secretions, however, give us very reliable information, and while not pathognomonic, is nearly so.

If stenosis exists and there is an excess of hydrochloric acid, free and combined, the case is benign; if it is diminished or absent, it is malignant. A carcinomatous ulcer at the pylorus is an exception to this rule, and I have seen two cases in which the excess of hydrochloric acid persisted to the end, but these are comparatively rare exceptions. Still more rare is a benign obstruction developing in a patient who has chronic acid gastritis with atrophy of glands, in which the hydrochloric acid is diminished. These exceptions should not divert you from the fact that the rule given above is true in probably 98 to 99 per cent of all cases.

Let me briefly report a case to illustrate the mode of procedure:

The patient in question was a lady, 55 years of age; she was married and had two children; family history was good and her own health had been excellent, excepting at her fifteenth year she had some trouble with her stomach, which was attended with daily pain and occasional vomiting. This continued about one year, after which she fully recovered and had no illness of any character until the present trouble. Three years ago she noticed that she would occasionally become bloated and there was rumbling in the bowels, and fourteen months ago she began to vomit. The vomiting would recur daily, sometimes once and occasionally two or three times daily, usually four or five hours after meals, and the quantity ejected was generally large. About this time she began to use lavage which was continued for one year, giving her temporary relief. The vomitus often contained food taken the day before, and the quantity sometimes was as much as a gallon. She had never vomited blood, and never had any severe pain; her bowels were generally constipated. Her normal weight was 206 pounds, and at the time she applied for treatment she weighed just 100 pounds. On physical examination I note first that she had a normal habitus, the abdominal wall was flaccid and through it, the dilated stomach and the peristaltic wave could be distinctly seen, the greater curvature was four finger-breaths below the umbilicus.

The contents of the stomach was 120 ounces and was removed eight hours after taking food. In this the free acid was 50, and the total acidity 120. I then washed out her stomach thoroughly, and that evening had her eat a few raisins; the next morning gave her a test breakfast (two oz. of bread with four-fifths pint of water) and an hour after, removed the specimen for examination. The raisins were found and the stomach contents yielded a free acidity of 40, total acidity of 90 and the rennin test was 50 per cent above normal. At that time she declined any operative interference, and I put her on a stenosis diet, that is, a diet in which the articles are soft and fluid; under this diet she gained in flesh and strength for a short time, but soon grew worse, lost weight, and finally decided to submit to an operation.

In this case you will note that in the first place she had stagnation, for we found the articles from the day before. She had gastrectasia, which was easily discerned by inspection and palpation. We know also there was insufficiency because of the stagnation and know, too, from the fact that the total acidity was above normal, that the disease was not carcinoma. I did a pylorectomy after the method of Kocher. She made a full and complete recovery, and since that time has been entirely well.

My object in writing this paper is to bring distinctly to your mind the symptoms which will enable you to make the diagnosis of pyloric stenosis, and also to differentiate the malignant and benign, and not to enter into a discussion of the technique of operation.

THE TREATMENT OF CHLOROSIS.

GEO. F. BUTLER, M. D.

CHICAGO, ILL.

THERE are four important things to do. There may be others. 1. Eliminate. 2. Regulate diet. 3. Rest, in plenty of fresh air and sunlight. 4. Administer hematics.

The bowels must be kept open. Constipation with its accompanying autotoxemia predisposes to anemia, and if it continues, makes the condition worse.

A saline laxative should be given every morning. Aloin or some pill containing it is often of great value. A good combination is: Aloin gr. 1-25, strychnine sulphate gr. 1-500, atropine sulphate gr. 1-2500, oloeresin capsicum gr. 1-500; emetine gr. 1-500, with a trace of bile. From three to six of these may be given three times a day. They will tone up the bowels and serve to overcome chronic constipation.

The diet should be light, nutritious and capable of easy digestion. Milk is an excellent food, but falls short in that it contains too little iron, and large quantities must be taken to satisfy the patient. Animal food, soups and broths, are indicated in small quantities often repeated. Farinaceous food alone will not suffice. The blood must be built up by an increase in the formation of blood corpuscles. To secure this the diet must be fairly rich in nitrogen.

It should be gradually made more stimulating, and a little burgundy, port, or maderia wine may be profitably given.

Rest in bed in a well-ventilated and well-lighted room, or on a couch out of doors, must be insisted upon for a while. It should be remembered that in chlorosis the cardiac muscle underoes fatty changes, and if the heart-wall is to recover itself and perform its function normally afterwards it must have as much rest as possible during the treatment.

As the patient improves, change of place and scenery, with out-of-door exercise, which inspire the psychical impulses and give a new direction to the thoughts, are all very useful.

Iron in some form is necessary. Blaud's mass freshly prepared is usually preferred. Give one pill three times a day, after each meal, the first week of treatment; during the second week two pills three times daily, and during the third week three pills three times daily. The dose may be diminished, but the patient should have some salt of iron for three months at least. Not uncommonly, the anemia will assume an obdurate persistency, and defy your best laid schemes.

Under these circumstances the patient should go to a chalybeate spring. The amount of dilution is a matter of the greatest moment in attempting to bring the system under the influence of chalybeates in many cases. Iron is more effective when taken with large draughts of water. Under certain conditions, water is a hematic. Not only does water wash away the accumulated waste matter, but in doing so it paves the way for the growth of new material.

The cheerful society and habits of others at chalybeate springs form a great incentive to invalids, who are inclined to be despondent, to exert themselves, and so aid in their recovery.

These facts alone often make the difference between failure at home and success at a spring.

The arsenate of iron, 1-6 gr. three times a day, increased if necessary, is a powerful remedy in chlorosis.

Strychnine, quassin, or some other equally good bitter tonic, may be given before meals if the appetite is poor.

Hydriatic measures, such as cold sponging over the spine, and inside and outside the thighs; general graduated cold baths with brisk rubbing, cold abdominal douche, and general massage, will be found of great benefit. Cold water properly applied is one of the most valuable curative measures in chlorosis.

Quite often it will be found that the iron simply passes through the bowels and is ejected, or else it accumulates in the liver, in both cases failing to be utilized and assimilated into a living part of the vitalized organism. In this case it has been found that the addition of nuclein solution to the prescription, in doses not exceeding a drachm daily, preferably administered by being dropped on the tongue, apparently causes the fixation of the iron in the blood and tissues; and the gain will far exceed that accruing from the use of either iron or nuclein alone.

JUGLANS is a good vermifuge and it is claimed that it has destroyed tape-worms.

NEW MEDICAL COLLEGE ORGANIZED.—The College of Physicians and Surgeons of Little Rock has been incorporated by Drs. Joseph P. Runyan, William P. Illing, David C. Walt, Arthur E. Sweatland, Charles C. Stephenson, Joseph P. Sheppard, Beauregard W. Flinn, Charles R. Shinault, S. Paul Vaughter, Edwin Meek, Thomas E. Hodge, George M. D. Cantrell, William B. Hughes, W. B. Smith, Emmet N. Davis, Clinton P. Meriwether, Daniel R. Hardeman and Rezin W. Lindsey, with a capital stock of $100,000, of which $55,000 has been subscribed, to conduct a school for the teaching of medicine and surgery in all their branches; of pharmacy and dentistry; a training school for nurses, and to maintain and operate a sanitarium and hospital. The officers chosen are as follows: Dr. Charles R. Shinault, president; Dr. George M. D. Cantrell, vice-president; Dr. William P. Illing, secretary and treasurer, and Drs. Charles R. Shinault, William P. Illing, David C. Walt, Arthur E. Sweatland and Edward Meek, directors. The board of directors, at a meeting, July 14, elected Dr. Jospeh P. Runyan, dean, and Dr. William P. Illing, secretary of the college.

The directors also elected the following members of the faculty: Dr. Arthur E. Sweatland, professor of anatomy; Dr. Thomas E. Hodges, associate professor of anatomy and lecturer on osteology; Dr. S. Paul Vaughter, associate professor and demonstrator of anatomy; Dr. Beauregard W. Flinn, professor of physiology; Dr. Emmet N. Davis, professor of chemistry; Dr. Rezin W. Lindsey, professor of clinical medicine; Dr. George M.D. Cantrell, professor of physical diangosis and diseases of the chest; Dr. David C. Walt, professor of the theory and practice of medicine; Dr. Clinton P. Meriwether, professor of materia medica and therapeutics; Dr. Edwin Meek, professor of obstetrics; Dr. Daniel R. Hardeman, professor of diseases of children; Dr. William P. Illing, professor of mental and nervous diseases; Dr. C. Travis Drennen, professor of syphilology and dermatology; Dr. Charles C. Stephenson, professor of disease of the eye, ear, nose and throat; Dr. Joseph P. Sheppard, professor of genito-urinary diseases; professor of pathology, to be supplied; Dr. Joseph P. Runyan, professor of surgery; Dr. Charles R. Shinault, professor of gynecology; W. B. Smith, professor of medical jurisprudence and M. E. Dunaway, professor of English and literature. The adjunct professors and clinical assistants will be supplied later.

ENONYMIN is claimed to be an excellent remedy for prostration with irritation of nerve centers.

THE MEDICAL FORTNIGHTLY

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EDITORIAL

The Toronto Meeting of the British Medical Association.

THE recent convention of the British Medical Association in Toronto was easily the most important medical event of the year, for the American continent, if not for the world, and it is a matter of congratulation to Americans that so many of our physicians were able to be present. The Association convened on the morning of the 21st, the general sessions being held in Convocation Hall and the thirteen sections meeting in the neighboring buildings of Toronto University. As a meeting-place the University left nothing to be desired, the buildings are splendidly arranged for the purpose and the Campus, or Queen's Park as it is called, made the surroundings charming in the extreme. Unfortunately the days of the meeting were so extremely warm that life was a burden for those who had gone North with an expectation of finding a very different temperature; the heat to a degree affected the enthusiasm of the gathering, but there being no other adverse condition no material lack of interest was manifest, and meeting was ultimately a tremendous success.

The organization of this Association attracted considerable interest among the American visitors, the committees and subcommittees, with their various ramifications seemed complicated, and to some extent confusing, but the machinery worked with such smoothness as indicated absolute understanding in every department, a matter which does not always so noticeably exist in our own larger gatherings. Visitors from America were accorded all privileges of members for the time, wearing the member's button and being welcome at all meetings and to the numerous entertainments offered by the Provincial organization.

A matter of not a little interest was the wearing of Academic regalia by the officers, speakers and invited guests at the general sessions. The impressiveness of ceremonial at these sessions is a thing unusual in America and might be advantageously copied by us.

The principal addresses of the meeting were the Address in Medicine by Sir James Barr, M.D., F.R.C.S., F.R.S.M., who spoke on "The Circulation Viewed from the Peripheral Standpoint;" the Address in Surgery by Sir Victor Horsley, M.B., F.R.C.S., F.R.S., on "The Technique of Operations on the Central Nervous System;" and the Address in Obstetrics by Walter Spencer Anderson Griffith, M.D., F.R.C.S., on "The Teaching of Obstetrics." Each of these addresses was a masterpiece, that of Sir Victor Horsley was especially remarkable, and we regret that every reader of the FORTNIGHTLY could not have heard it. Unfortunately it is of a character that we may not reproduce it. The work of the thirteen sections was uniformly excellent, the presence in each section of various celebrities from various corners of the British domain contributed materially to the interest for Canadians and Americans present. It was a great privilege to listen to such men as Drs. Norman Walker, J. Dundas Grant, Sir Thos. Barlow, Sir Wm. Broadbent, Osler, Adami, Murdoch Cameron, Sir Hector Clare Cameron, and others too numerous to mention. To us it was a little disappointing that so generous a place on the program was allowed the American profession, flattering though the fact is, for we desired the British to have the floor as much of the time as was possible. Among the papers read, by Americans were three by men from St. Louis, Drs. Jas. Moores Ball, Geo. Homan and H. W. Loeb doing the honors for our city in this.

Aside from the scientific entertainment of the occasion the members of the Association feasted and feted from their arrival to their departure. Various excursions were arranged, to Niagara, to the Thousand Islands, to Muskoka, and to many other points, and members of the Association generally availed themselves of so much as their time would allow. Those Americans who were a little apprehensive that our going was at a bad time, as the Canadian profession would have its hands full with the entertainment of its guests from across the ocean, and would have little time for near neighbors, were given a demonstration of what genuine Canadian hospitality means, and none of us returned with any doubt of what Canada can do when she intends doing it.

The total registration up to noon, August 24, was 1,986, of whom 650 were from the United States. Of these 1,390 were registered as members and 596 as visitors.

Of those registered as members, 1,078 were from the Dominion of Canada, 145 from England, 48 from Scotland, 19 from Ireland, 4 from Wales, 17 from the British colonies, 3 from Continental Europe, and 54 from the United States, chiefly from the following states: New York, 9; Illinois, 7; Massachusetts, 5; Michigan, 4, Missouri, 1, etc.

Of the 596 visitors, 8 registered from Europe, 26 from Canada, and the remainder, 562 from the United States.

The following physicians from Missouri attended the meeting: Drs. W. B. Dorsett, W. E. Fischel, Roland Hill, Geo. Homan, Jas. Moores Ball, Howard Carter, Jno. M. Dean, Thos. A. Hopkins, Chas. H. Hughes, J. Ellis Jennings, H. W. Loeb, Frank J. Lutz, Mary H. McLean, K. C. Millican, E. W. Spooner, A. H. Meisenbach, A. J. Steele, St. Louis; O. L. McKillip, C. A. Ritter, Kansas City; Chas. Wood Fassett, St. Joseph.

The Lid.

It is now some months since the Governor inaugurated the enforcement of the law requiring that saloons be closed on Sundays, no community has felt the effect of this more than St. Louis, for here the requirement has been enforced and continuously effective longer than at any other point. It would seem that the benefit or detriment of the law must by this time be generally recognized, though there is really no concerted sentiment on the subject. Our coroner tells us that there has been a material decrease in homicide; from the dispensaries we learn of a largely decreased number of stabbings, shootings, etc., and from the police department comes a definite statement that arrests are fewer from the offences of intoxication, fighting, beatings and the interference with the rights of others in ways which call for police interference; the citizens of St. Louis appreciate the unquestionable fact that we have a more orderly city than we had when we were "wide open." Whether there will be demonstrated better health conditions later, which may be a result, it is still too early to predict, but it would appear possible. On the other side, we have our ideas of inherent liberty of action, and our dislike for anything which may even in a slight degree interfere with the catering to our individual appetites, and we do not like to be held responsible for the errors of others, or to be deprived of something because another lacks our balance and commits excesses. Impartially weighing the evidence leaves no doubt that the lid is a good thing and should continue. The lid has spread from Missouri to all sections of the continent and is, in some places, more strictly on than here, closing saloons in the evening, covering other lines of business in its Sunday requirement and in places working a real hardship, but in spite of this we believe that the lid works to the advantage of the vast majority of our people. In this connection it was a matter of not a little interest that men of such scientific position as Sir Victor Horsley and Professor Woodhead, of Cambridge, have lately declared before the British Association that alcohol is worthless, or nearly so, as a medicine, and that milk and soda is a better tonic for the sick, and in this they were upheld by many of our foremost physician as well as a number from abroad, when this can happen the man who make "medicine" an excuse for his daily dram had better be looking for another excuse, for he is losing his backing. We are not quite ready to accept Sir Victor's belief as final, but we can agree that mighty little that is good comes from it except when it is used as a medicine.

Speaking of lids, the association journal tells us that France is to have the real thing in this line:

"A bill has been before the French parliament for fifteen years and has finally been passed which imposes Sunday rest. Compulsory closing of shops on Sunday is now required, and cessation of week-day work is imperative on all employes or workmen in a manufacturing or commercial establishment or its dependencies, whatever its nature, public or private, lay or clerical, even if it has a character of professional instruction or benevolence There are numerous exceptions provided for. Whenever it is evident that the Sunday rest for all the personnel of an establishment would be prejudical to the public or would compromise the normal function ing of the establishment, the day of rest can be given on some other day than on the Sunday or divided among several days, or the personnel of the establishment may take turns in the Sunday rest. A special permit is necessary to have a right to these exceptional privileges of remaining open all or part of Sunday, except in the case of hospitals, dispensaries, drug stores and saloons. The Semaine Medicale laments this special favor granted to saloons, stating that there is one saloon in France for every fifteen adult males, and their closing on Sunday would be a national blessing."

The Insane Lovers.

Dr. John W. Stevens calls attention to this subject as one of much importance to the general practitioner who first sees these cases (Med. Record, Aug. 18). They are not uncommon in asylums and in neurological practice. The patient may seem clear and rational on all other subjects, so that for some time she is considered entirely sane. The maniacal insane lovers differ in certain prominent features from those of the paranoid class. In the former group the origin of this love is always to be traced to the abnormal sexual excitement, increased susceptibility to stimuli, facilitated release of impulses, and the lack of the restraining influence of the ethical sensibilities in the presence of the elation and sense of well-being. At the beginning of this condition delusions and hallucinations are nearly always absent. In the paranoid case this love is only a part of progressive and systematized delusional state. A strangely erotic element is not necessarily present. The maniacal patient often recognizes the abnormal nature of her impulses, while the paranoiac never does. The paranoiac is practically always monogamous, the maniacal often polygamous. In the latter the love disappears with the subsidence of the active symptoms of the individual attack, while in the former it remains throughout life. These patients should be carefully looked out for, not only for their own sake, but for the sake of their victims.

Tri-State Meeting.—The Tri-State Medical Association held its thirty-third annual meeting at Put-in-Bay, Ohio, July 31 and August 1 and 2. Dr. Charles D. Aaron, Detroit, Mich., was elected president; Dr. Theodore F. Wood, Angola, Ind., vice-president; Dr. William F. Shumaker, Butler, Ind, secretary, and Dr. Joseph A. Weitz, Montpelier, Ohio, treasurer.

The American Orthopedic Association.—The twentieth annual meeting of the American Orthopedic Society was held in Toronto, Ontario, August 20-23. The Association elected the following officers for the coming year: President, Dr. Joel E. Goldthwait, Boston; vice-presidents, Dr. Henry Ling Taylor, New York; and Dr. Ansel G. Cook, Hartford, Conn.; secretary, Dr. Robert B. Osgood, Boston; treasurer, Dr. E. G. Brackett, Boston; executive committee, Dr. John Ridlon, Chicago; Dr. D. R. Townsend, New York; Dr. H. Augustus Wilson, Philadelphia; Dr. Goldthwait and Dr. Osgood, ex-officio.

Organization Meeting.—The Committee on Organization of the proposed "Medical Association of the Southwest," has called a meeting at Oklahoma City, for October 30 and 31, at which time joint sessions will be held with the Tri-State Medical Society of Texas, Oklahoma and Arkansas. Dr. F. H. Clark, temporary secretary, El Reno, Okla.

Sleeping Sickness.—For the sleeping sickness there is no remedy, declared Professor Koch in a recent lecture on his return from a journey of investigation in Africa. He hoped, however, that the infection might be ended by the extermation of the insect (which propagates slowly), by burning the undergrowth at its favorite home.

The German Birth-rate.—A statistical report recently presented to the German imperial chancellor is said to show that the birth-rate Germany is receding rapidly at any rate in in the towns. In 1904 the birth-rate was 30.5 per 10,000 inhabitants against 30.9 in 1903, 32.1 in 1902, 33.4 in 1901, and 33.7 in 1900. The decrease, therefore, is continuous, and has begun to cause anxiety.

Mississippi Valley Medical Association.—The next meeting of the Mississippi Valley Medical Association will be held at Hot Springs, Arkansas, November 6, 7 and 8, under the presidency of Dr. J. H. Carstens, of Detroit, Mich. The annual addresses will be delivered by Dr. Frank Parsons Norbury, Jacksonville, Ill., in Medicine, and by Dr Florus F. Lawrence, of Columbus, Ohio, in Surgery. Dr. Norbury has chosen for the subject of his address, "Clinical Psychology," and Dr. Lawrence will discuss in his address, "Surgical Principles and Theories." In addition to these addresses there will be the annual address of the President, Dr. Carstens. Elaborate arrangements have been made by the local profession of Hot Springs to entertain the visiting doctors and their wives, the meeting being held at the "Eastman" hotel, which will be specially opened in advance of the season to accommodate the Association. A cordial invitation is extended to every physician in the valley to attend this meeting for which a large number of interesting and valuable papers have been promised. The headquarters will be at the beautiful "Arlington," where reduced rates will be in effect for the occasion. We would urge our readers to make early reservation of rooms, and avoid the risk of being crowded out, as the attendance is sure to be large. Communications regarding papers should be addressed to the secretary, Dr. Henry E. Tuley, 111 W. Kentucky street, Louisville, Ky.

THE REVIEWER'S TABLE

Books, Reprints, and Instruments for this department, should be sent to the Managing Editor, Century Building, St. Louis.

THE WORLD'S ANATOMISTS. Concise Biographies of Anatomic Masters from 300 B C. to the Present Time, Whose Names have Adorned the Literature of the Medical Profession, By G. W. H Kemper, M. D., Professor of the History of Medicine, Medical College of Indiana, Indianapolis. Ind. With eleven illustrations. Philadelphia: P. Blakiston's Son & Co.

This little booklet should be elaborated into a book of greater size and detail. There is a definite call for books dealing with medical history; these are days of increasing interest in the historical aspect of things generally and medicine is feeling the drift. Dr. Kemper has given us an admirable book, full of interest and artistically gotten up, and the only suggestion that occurs to us for its improvement is that it is too condensed for a work of its character.

A NON-SURGICAL TREATISE ON DISEASES OF THE PROSTATE AND ADNEXA. By Geo. W. Overall, A. B., M.D., Chicago. Chicago: The Rowe Publishing Co.

The good things which are in this volume are so many that it seems not a little unfortunate that there are some features which prevent giving it our unqualified approval. We cannot advocate the treatment of varicocele by the immersion of the scrotum in a medicated bath and passing an electric current through it, but we can approve of a vast majority of the practical suggestions of the author, and we regret that he has not been a little more conservative. Dr. Overall is unquestionably a clever and ingenious man; he largely devises his own instruments and they appear to be good if we may trust the illustration and description; however, from the contour of the bladder, as shown in these illustrations, we are not certain that the instruments are at all what they are pictured, the bladders though supposedly normal in contour, show an artistically perfect urachus widely patulous to its apex at the umbilicus.

If discriminatingly read in connection with larger treatises on these subjects, a vast deal of practical information which is available for immediate use will be found in the volume.

A COMPEND OF MATERIA MEDICA THERAPEUTICS AND PRESCRIPTION WRITING, WITH ESPECIAL REFERENCE TO THE PHYSIOLOGICAL ACTION OF DRUGS. By Samuel O. L. Potter, M.D., M.R.C.P. (Lond.) Seventh Edition Revised and Enlarged. Cloth. Pages 292. Philadelphia: P. Blakiston's Son & Co., 1912 Walnut street. 1906.

It is probable that few of our readers are unacquainted with this book, having possessed one or another of its earlier editions. Revision has increased its value and made it without question the best condensation of the subject procurable. There is no other one of the Blakiston Compends upon which the popularity of the series could with such certainty depend, yet each of its fellows is a work of great excellence. The book may be unqualifiedly recommended to students and to physicians wishing a condensed handbook for speedy reference. It is accurate, up-to-date, and presented in an attractive form.

"Running Water."— The September chapters of A. E. W. Mason's new novel in The Century, "Running Water," a tale whose scenes so far are set chiefly in the Alps, bring a hint as to the title. Sylvia Thesiger, the girl of elusive charm and doubtful antecedents, is on her way to her first mountain ascent, and there is a chance meeting with Chayne, the fine, strong character whose love of the Alps and Alpine climbing is his one passion. "I shall hardly know whether I sleep or wake, with the noise of that stream rising through my window," Sylvia tells Chayne, "for so far back as I can remember, I always dream of running water." The words laid hold upon Chayne's imagination and fixed her in his memories. He knew nothing of her really except just this one curious fact—she dreamed of running water. Somehow it was fitting that she should. There was a kind of resemblance; running water was in a way an image of her. She seemed in her nature to be as clear and fresh; yet she was as elusive; and when she laughed, her laugh had a music as light and free. The fiction number will include also new chapters of Anne Warner's mirthful "Seeing France with Uncle John," and short stories from Edgar Jepson, Grace S. H. Tytus, Alice B. Morrison, Dorothea Deakin, and Maurice Francis Egan, who contributes another "Sexton Maginnis" tale.

Medicines Best Given Alone.—Acetate of lead, nitrate of silver, iodide of potassium, and bichloride of mercury are all best prescribed alone, being incompatible, or at least ineligible, with almost everything, the acetate of lead and nitrate of silver may be prescribed with opium, and iodide of potassium and bichloride of mercury with sarsaparilla, or with each other.

Disinfecting Confessionals.—On the advice of the Council of Hygiene, the Mexican government has ordered that the confessionals in all three churches of the city of Mexico must be regularly disinfected with the purpose of preventing the transmission of infectious or contagious disease. They are used by crowds of persons of both sexes and might easily become contaminated. Priests disobeying this order or showing negligence in carrying it out are liable to imprisonment.

REPORTS ON PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

INTERNAL MEDICINE.

O. E. LADEMANN, M. D.

Jaundice, with Special Reference to its Diagnostic Value.—Hansel's (Medicine, July, 1906) paper discusses the clinical aspect of jaundice and for the purpose of description uses the terms direct and indirect as being more applicable than older classifications, as obstructive and non-obstructive or obstructive and toxemic, because in reality all jaundice is obstructive, the toxemia variety depending upon increasing viscidity of the bile or a swelling of the mucosa of the bile ducts which leads to obstruction. Under the heading of direct jaundice he applies to cases in which the original cause is within or immediately without the bile passages. All other jaundice due to causes originally remote from the liver and its bile passages, or in other words general conditions, may be classified as indirect. The former include those conditions which directly impede the excretion of bile, such as foreign bodies within the ducts consisting of gall stones, plugs of mucous, infective concretions and particles from the duodenum. These may cause a mechanical obstruction, or secondarily set up a cholangitis, which by swelling of the mucosa produces a narrowed lumen and arrests the biliary excretion. Gastroduodenitis by causing a swelling at the opening of the common duct may produce jaundice directly. Stenosis of the duct from cicatrices due to ulceration following biliary colic, stenosis from chronic inflammation of the duct wall, and impacted gall stones, all act mechanically in producing a direct icterus. Adhesions of adjacent structures, tumors in close proximity, and enlarged glands in the transverse fissure of the liver cause obstruction by direct pressure. Direct jaundice may also be caused by diseases of the liver, such as Weil's disease, acute yellow atrophy, passive congestion, cancer, biliary hypertrophy and common cirrhosis. Rarely a direct jaundice occurs in syphilitic, amyloid and fatty liver. Coming within the latter class (indirect) may be placed the slight and transitory jaundice due to fright, anger, anxiety and concussion of the brain; the icterus occurring in the course of infectious diseases, as scarlet-fever and the like, and jaundice resulting from other sources, as snake bites, drugs, as chloroform, ether phosphorus, etc. With a brief description of the diseases associated with direct jaundice, the writer summarizes his article as follows: 1. Jaundice due to gall-stones is accompanied by colic. 2. Jaundice with colic is due to gall-stones. 3. Chronic obstructive jaundice with an atrophied gall-bladder is generally due to gall-stones. 4. Chronic obstructive jaundice with a dilated gall-bladder is due to causes other than gall-stones, usually a tumor of the pancreas or the pylorus. 5. Repeated attacks of jaundice, in a patient who is well in the intervals, point to gall-stones or gastroduodenal catarrh—painful when due to stones and painless when caused by the catarrh. 6. Persistent jaundice with bile pigments in the stools, accompanied by enlargement of the liver and spleen and no ascites, indicates biliary cirrhosis or passive congestion. 7. Jaundice and ascites combined may be either common cirrhosis or cancer of the liver. 8. Jaundice, ascites and enlargement of the liver are almost pathognomonic of cancer of the liver.

These conclusions are rather far fetched (editor).

The Occurrence of Occult Hemorrhage in Typhoid.—Tileston (Boston Med. and Surgical Journal, July 12, 1906) examined the stools in 68 cases of typhoid fever by means of the guaiac and aloin tests for blood pigments. The technic employed was practically the method of Boas. The results of his examinations were: eighteen cases out of the 68 gave positive tests at some period during the course of the disease. One of these was complicated with enteritis to which the presence of blood was probably due, there remain 17 or 25 per cent which showed the presence of occult blood. In all, 422 stools were examined, of which 42 were positive, i.e., 10 per cent. A division into groups, according to the severity of the disease, gave the following resutls: fifteen mild cases, 3 positive, 20 per cent. Thirty-nine moderately severe, 10 positive, 26 per cent. Fourteen severe or fatal, 5 positive, 36 per cent. On the day of the positive reactions the temperature in most cases, was considerably elevated; in five, however, it had nearly or quite reached normal. In eleven cases diarrhea was present, while in six it was absent. From these examinations and the work of others, the author deducts the following conclusions: 1. Occult hemorrhages may be detected by the guaiac and aloin tests in about 25 per cent of all cases of typhoid fever. 2. The application of these tests is of little value as a means of foretelling gross hemorrhages. 3. It is of very little value in diagnosis, owing to the inconstancy and comparatively late appearance of positive reactions. It seems probable that more complicated chemical methods would show a larger percentage of positive results, for the

separation of sloughs must always be attended by some hemorrhage.

The Present Status of the Bedbug in the Transmission of Human Diseases.—Girault's (Journal A.M.A., July 14, 1906) paper is intended to point out what is now known regarding the carrying of disease germs by this insect, a question, he believes, should be of interest to all, especially those who live in large crowded cities, where its presence is becoming a serious factor. Scientists, medical men and entomologists have demonstrated beyond doubt, that fleas, house flies and mosquitoes carry and transmit certain dangerous diseases. Fleas carry bubonic plague; house flies, numerous pathogenic bacteria, including those of cholera, bubonic plague, tuberculosis and typhoid fever, also myasis and even some of the parasitic worms that live in the intestines of man; mosquitoes carry yellow fever and malaria and also that most horrible filarial disease known as elephantasis. Although the bedbug has been known for centuries and its literature comprising as high as five hundred odd articles, but very little, at present, is really known concerning its habits and life history. On the contrary, much has been conjectured. In addition to this, its host relations are entirely unknown. If it is able to live on the blood of man only its scope in potential transmission of disease is limited. But if it is able to subsist and breed also by attacking the small mammals found associated with man, such as mice and rats, its scope in potential transmission of disease is at once greatly enlarged. It is certain that blood comprises its only food, in spite of what has been said to the contrary. The experiments of the author seem to prove this question, as bedbugs were found feeding on dead mice. A closely related species, the foul bug, which associates with pigeons and chickens, which were found to be fond of human blood, readily attacked living mice. It would seem from the literature the author reviews as if the bedbug could be the carrier of relapsing fever, leprosy, bubonic plague, anthrax, tuberculosis, even syphilis and typhoid.

Albumin: Recognition of the Albumin Bodies in the Urine.—Hastings (Med. Rec., July 7, 1906) says that many of the abluminbodies which theoretically might occur in the urine may be excluded from consideration for various reasons: serum-albumin, nucleoalbumin, serum-globulin, and Bence-Jones albumose should be considered. For purposes of excluding false reactions due to bacterial disintegration the urine should be examined within six hours after voiding, unless the reaction is massive. The most reliable test for serum-albumin in the urine is that of "salting" the urine with a saturated solution of "salt." (sodium chloride), acidulating with 50 per cent acetic acid, and heating to boiling; this throws down all traces of serum-albumin and prevents a nucleo-albumin reaction.

LEGAL PHASES OF MEDICINE.

E. S. McKEE, M. D.

The Legal Conditions of the Medical Use of the Roentgen Rays.—Prof. Debove before the Academié de Médicine called attention in a valuable paper to the dangers to which man may be exposed through the use of the Roentgen rays by persons not legally authorized to practice medicine. A committee was appointed which has made a very full report on the subject. The following conclusions of the commission were unanimously carried by the Academié: "Considering that the medical use of the Roentgen rays may cause grave accidents, that certain practices may create a social danger; that only doctors in medicine, officers de sante and qualified dentists (in so far as concerns odontology) are capable of interpreting the results obtained from the point of view of diagnosis and of the treatment of disease, the Academie is of the opinion that the medical application of Roentgen rays by persons not holding the above diplomas constitutes an illegal practice of medicine."

Anesthesia Before the Law.—A recent trial in France has caused considerable interest on account of a man who was very much afraid of an anesthetic, dying after the administration of a few whiffs (kind not mentioned). Action was brought by his relatives and the doctor was condemned to pay 8,000 francs, about $1500. The judge ruled that the anesthesia was not absolutely necessary, as the man's life was not in danger. He said it was the duty of the medical attendant to warn the patient of the dangers which he was incurring in taking an anesthetic, but to assure him in proper cases that he can continue to live for a long time in partial comfort as he is. The patient had a tendency to syncope and to alcoholism. As it is well recognized that fear may cause death it may be well be imagined that the emphatic warning recommended by the judge might of itself cause death, in fact cases have occurred where the patient has died at the approach of the anesthetist. Velpeau addressing the judge in a similar trial shortly after the introduction of chloroform said: "You hold in your hands the future of surgery. The question concerns the public more than

the medical practitioner. If you condemn the surgeon who uses chloroform none will ever use it again. No practitioner knowing that for an accident impossible to foresee he will be held accountable, will ever administer it. It is for you to maintain the abolition of pain or to restore it."

The Examination of Prostitutes not Privileged.—Before the French Society of Legal Medicine M. Butte argued that no violation existed. The medical men who are attached to that particular department in question of the State are not, so far as these duties go, practising medical men. They act simply as experts and as delegates of the police, just in the same way as do other inspectors. The woman who comes to him does not confide in him, she comes because she must. This being so there is no secrecy about the matter, and consequently no violation. It is claimed by some objectors to the police examination of prostitutes that the medical man whose duty it is to carry out the examinations cannot without violating his oath of professional secrecy, legally fulfill such duties.

The Signs of Death by Drowning —Vieira before the International Congress at Lisbon considered when a body is found in the water was death due (1) to asphyxia consequent upon immersion, or (2) to some other cause. Most writers believed death from other reasons than asphyxia to be rare. Vieira on the contrary, thought it relatively frequent. When death was not due to asphyxia, that is took place so suddenly that the person had no time either to draw water into the lungs or to swallow it, the post-mortem appearances due to this must be absent. There are at present, he said, hardly any evidences to determine whether death under such circumstances is due to respiratory syncope, to cardiac syncope, or to meningeo-encephalic congestion or hemorrhage. To illustrate, he described the following case: The body of an infant was found in a well. The parents when brought to trial said that the body of the infant was not thrown into the well until it had died a natural death in their arms. The body was that of a healthy infant, there were no signs of strangulation. and post-mortem appearances did not warrant the making of a more definite statement than that the death might have been due to respiratory syncope. The parents were therefore acquitted.

Damages for Death of a Dentist.—A dentist, an acqaintance of the writer, by name of Morhard, residing in New York, went into the cellar to see what was wrong with the electric lights and was electrocuted. His wife sued the electric light company and obtained judgment for $40,000. The case was appealed and the Supreme Court affirms the decision of the lower court. It says it does not think this amount excessive, it appearing that the dentist was 37 years of age at the time of his death; that his income from his dental profession had been from $17,000 to $20,000 per annum, and that he left three children, the eldest being 11 years of age, besides a posthumous child born six months after his death. It would be interesting to learn how much of this, finally, the lawyers allow the widow and orphans.

Prescription Not Competent Evidence of Insanity.—The case of Ames vs. Ames the Supreme Court of Nebraska holds that the fact that the attending physician prescribed for the patient certain drugs which are administered to the insane is not competent evidence tending to establish the insanity of the patient. Assuming that the patient was under treatment, as indicated by the prescription for some disease affecting the mind the court ruled that it only reflected the opinion of the prescribing physician at the time the prescription was given. If instead of a prescription addressed to the pharmacist the physician had written him a letter in which he expressed the opinion that he was insane, will it be claimed that such a letter would be admissible in evidence on the question of the patient's sanity? The prescription certainly stands on no better footing.

The Man Who Snores.—The Supreme Court of Alabama says that sleeping cars are not obliged to admit persons of gross and vulgar habits, the insane or persons suffering from contagious diseases. How about the man who snores?

Reciprocity.—Dr. William Warren Potter, of Buffalo, editor of the Buffalo Medical and Surgical Journal, wrote for that most excellent series of prize essays in the N. Y. Medical Journal, on the subject of Reciprocity. His essay very justly took the prize. He thinks that when the preliminary or entrance requirement, the length of term and method of collegiate training, and licensing examinations are placed upon an uniform basis throughout the country, the problem of reciprocity in medical licensure will be solved. This, he thinks, to be the only equitable solution of the perplexing question: Of what avail is reciprocity unless founded on justice? Surely an enforced interchange of licensing courtesies would be worse than none; it would be irritating, unfair and ephemeral; whereas if founded upon uniformity of standards, it would be pleasing, just and enduring.

It seems strange, almost absurd, that entrance requirements have not already been placed upon a basis of uniformity. It is well nigh scandalous that it has not been established. Ignorance should not be tolerated anywhere among those who contemplate entering upon the study of medicine and the colleges throughout the length and breadth of the land should agree without unnecessary delay upon the minimum of preliminary or entrance qualifications. This once done it would be a comparatively short step to the standardization of the methods of teaching, as well as the length of the undergraduate terms. Finally, with these two essentials agreed upon, the licensing boards would be compelled to establish uniformity of methods of examination, and likewise, the states could no longer withhold indorsements of licenses. The Association of American Medical Colleges can be depended upon to establish the first two propositions, namely, the uniformity of entrance requirements and the length of collegiate terms and methods of teaching. It will then be "up to" the examining boards and state authorities, to use a trite expression of the day, to see that their methods become of uniform standard and that reciprocity is established with promptitude. I am resuaded, from considerable observation and experience, that interstate reciprocity in licensing is best accomplished through the avenues named, and indeed that only in this way can it be accomplished with fairness to all the variant interests, with lasting credit to the profession, and with substantial benefit to the licensees who expect to derive advantages from this privilege. Reciprocity was given considerable consideration by the president of the American Medical Association at Boston in his presidential address. Dr. Mayo thought that what was needed was a higher standard of requirements and more and better supervision of professional schools. At the present time each state has its own standard of requirements. The conditions now with reference to reciprocity in medical license are well nigh intolerable and restrain the individual freedom guaranteed by the constitution. The borders between states are imaginary lines, yet a physician on one side of the border could not relieve human suffering on the other side without becoming amenable to the law or subjecting himself to vexatious examinations which he had already successfully passed in his own state. This must be met and speedily, by agreement between examining boards as to the minimum of requirements. After all, this is but a part of the educational problem. If we can solve this, licensing boards could at once adopt more uniform examinations and reciprocity.

The Ownership of the Prescription.—Colorado Medicine is out with a new argument from analogy as to who owns the prescription. It states that the Supreme Court has decided an architect who "receipts for professional services" can protect his work and his client cannot build two houses on the same plans, while the architect who receipts for "plans and specifications forfeits his rights to ownership, therefore the patient who pays for professional services does not own the prescription. The best argument by analogy in this much debated question is that the physician's prescription is comparable to a ticket to a theatre seat or a railroad journey for one trip only, and this should be taken up by the agent, who complies with the order which it contains, and not repeated unless a new prescription or order was reissued by the physician or company.

Deaths from Diphtheria Inexcusable.—In a recent bulletin the Chicago health department states: "Every death from diphtheria should be made the subject of judicial inquiry, as other avoidable deaths resulting from negligence, culpable ignorance or criminal malpractice now are." This shows how thoroghly the value of antitoxin in diphtheria has been established.

The Value of Medical Expert Testimony.—(Bryce, Southern Clinic).—If the medical profession has made itself the laughing-stock of the people in any way, it surely has done so more through the medium of its so-called experts on the witness stand than by all other means. The readiness with which medical men may be found to testify on either side of any case and refute the testimony of each other is something remarkable if we are to look upon medicine, chemistry or surgery as anything of a science. The effect of such conflicting testimony by men supposed to be fairly or exceptionally representative of the scientific side of the profession is damaging to the entire profession, to the cause of the case pending in the courts, and to the moral tone of the witness's opinion and utterances. There is not the slightest doubt that personal friendship, pecuniary pressure, and prejudice are the largest contributors to this evil so frequently perpetrated in our courts in cases involving life, honor, property and happiness. The remedy in a measure consists in the selection of competent and unpurchasable medical experts, and in permitting no other kind of medical men to appear upon the witness stand, whether it involves the ownership of a hound dog or the chastity of some good woman whose profligate husband would exchange her,

under the lax divorce laws of our land, for the more attractive animal frequenting the resorts of the demi-monde. Regarding the competency of a medical witness, it should not be inferred that because a man stands well in his community as a general practitioner he is competent to give expert testimony in matters of which he is altogether ignorant from want of personal experience in his daily work. In matters concerning the insane, for example, we would attach far more value to the testimony and opinion of a sensible nurse or attendant in an insane asylum who had ample experience in such capacity than to any number of medical experts whose only expertness consisted in experience gained in the treatment of infantile flatulency or adult bellyache. Now, however honest and well-intentioned these men may be they lack the very qualifications for which they are summoned and are therefore liable to do more harm than good in their testimony as experts. They may be summoned to whitewash their friends or damage other testimony, but this is not expert testimony, and the juries of the land know it, have no respect for it, and it should not be allowed.

Major John M. Banister, of the United States Army Medical Service, giving his observations during three years spent in the Philippines, says that scarlet fever, diphtheria, and yellow fever are unknown in these islands. He remarks: "As far as I have been able to learn not a single case, of either of these diseases ever occurred in the archipelago."

Japanese Losses in the War.—According to the Tokio correspondent of the Times (London), the Japanese Minister of War, speaking at a banquet of representatives of the medical service, said that Japan at one time during the war had 1,200,000 troops under arms. Of this number 70,000 died and 310,000 were wounded or sick, but only 15,000 died of sickness, and 9,800 died of wounds after coming under treatment.

The Pulse in Tuberculosis.—M. Durand says the pulse rate is a valuable diagnostic sign in tuberculosis as indicating the severity of the disease and its probable duration. If the pulse rate is maintained above the condition is serious, and desperate if it exceeds 120 for several days. Thus examination of the pulse enable us to recognize curable forms of tuberculosis or at least those of slow progress. In doubtful cases of consumption don't fail to take the temperature. A slight rise toward night is one of the first signs.

SOCIETY PROCEEDINGS

THE MEETING OF THE BRITISH MEDICAL ASSOCIATION.

Toronto, Canada, August 29, 1906.

I.

The British Medical Association held its annual meeting at Toronto, August 21-25, under the presidency of Dr. Reeve, the dean of the Medical faculty, University of Toronto. Toronto is a beautiful city, and the University buildings are well adapted for the purposes of a congress. The hospitality of our Canadian cousins has been unbounded, and I think everyone has been charmed with his visit to the great Dominion. Some 1600 members and visitors attended, the British

R. A. REEVE, M. D.

contingent numbering about 200, and we were glad to welcome a large number of our United States friends. Altogether the Congress has been one of the most successful on record.

Dr. Reeve in his presidential address dealt largely with the history of medicine in the Dominion and in Toronto, and viewed some points in the modern progress of the art of healing.

The address in Surgery was delivered by Sir Victor Horsley, who took as his subject "The Technique of Operations on the Central Nervous System." It was a brilliant exposition, admirably delivered before a large audience in the fine new Convocation Hall of the University, and illustrated with a number of excellent lantern slides. Sir Victor first mentioned the cardinal symptoms of intra-cranial growths and discussed at what period an operation should be under-

taken. He is of opinion that if the symptoms do not yield after three or four months of medical treatment, an exploratory operation should be done. If the growth could not be removed, the opening of the skull would do good, inasmuch as it would infallibly prevent blindness supervening on the optic neuritis; in itself no small thing, since these cases might go on for years. As regards optic neuritis his experience warranted him in saying that this first appeared always on the same side as the lesion. The chief risk of the operation was from shock; the patient should be kept warm with hot water cans on the operation table, which should be fitted with a proper adjustable head rest, and throughout the operation, the brain should be kept irrigated with 1-5000 corrosive sublimate solution at a temperature of 115 deg. F. This prevented cooling of the nerve tissues and tended much to prevent shock and also stopped capillary oozing. The brain tissue should be handled as gently as possible. The skull should be opened by first making a trephine hole, then by marking out the area of bone to be removed with a saw, and finally removing the bone with bone forceps, all traction being directed carefully away from the nerve substance. There was never any need to remove parts of the brain in order to expose the growth; the brain could always be pulled aside with spatulas. All vessels, arteries and veins, should be ligatured as long as possible. Bleeding to the bone could always be arrested with wax, and troublesome venous oozing was at once arrested by the administration of oxygen. As regards anesthetic Sir Victor uses chloroform; by means of the Vernon Harcourt regulator this could be administered in any desired amount. While opening the skull and dura 2 per cent of chloroform in the air sufficed completely to anesthetize, but in the subsequent procedures often ½ per cent was enough to keep the patient sufficiently under the quantity being again raised to 2 per cent during the closure of the wound. Asepsis and antisepsis should be carried out with the greatest care, as operations on the central nervous system are particularly liable to be followed with septic infection.

Dr. W. S. A. Griffith delivered the address in Obstetrics on "The Teaching of Obstetrics," and Sir James Barr the address in Medicine on "The Circulation Viewed from the Periphery." Dr. Donald MacAlister was the president of the Therapeutic section and in his address advocated reciprocity between Canada and England in medical practice. As he is president of the General Medical Council in Great Britain he evidently spoke with authority.

Prof. Arthur Robinson, the president of the section of Anatomy gave some introductory remarks on the teaching of anatomy in universities and medical schools. He concluded as follows: "It should, therefore, be the object of anatomists to avoid entangling medical students in a superfluity of detail. They should insist upon a thoroughly sound knowledge of the general relations and arrangements of the more important organs and parts of the body, a good knowledge of the general principles which underlie the relationships and arrangements and the advantages derived from them. They should endeavor to make their students acquainted with the general laws of growth and development and with abnormal conditions so far as they are produced by deviations from general

SIR VICTOR HORSLEY.

laws of growth and development, and, carrying on the work done in the Biological Department, they should draw attention to man's relations to other animals in all cases where such relations are evident, and are instructive of the methods by which man has been evolved and the means by which he retains his place in the world. In addition, however, they must see that their students acquire a sufficient knowledge of the detail of the various parts of the body and their relationships to enable them to deal successfully with any emergency of daily life."

An interesting discussion on arterio-sclerosis engaged the combined attention of the sections of Medicine and Pathology, and Prof. Welch, Dr. Klotz, Prof. Aschof, and Dr. Clifford Allbutt among others took part in the discussion.

The following is a synopsis of th econtribution of Mr. Oskar Klotz, Resident Pathologist Royal Victoria Hospital, to the discussion on the Forms of Arterio-sclerosis, their Classification and Experimental Production: Experimental arterial lesions which can be produced in animals are two kinds: either a degenerative one, affecting mainly the media, or a regnerative one, in which the intima proliferates, while little or no degenerative change is seen. It is found, too, that the substances which are used to produce the former belong to the class of high pressure does not in itself lead to the medical lesions noted; there is a direct degenerative action of the drug on the muscle fibres of the media. Elastic fibres become affected later. The latter once giving way leads to aneurismal dilatation. The degeneration is of a fatty nature. The intimal regeneration is consequent to bacterial toxins, the proliferation being confined to the endothelial and subendothelial cells. When only intimal lesions are present aneurisms are not formed. The character of these lesions can be compared to those in man to a certain extent. Here lesions entirely of a degenerative nature are met with in the Moenckeberg type of peripheral arterio-sclerosis, and with the form of this disease as it is found in the aorta, both of which processes are confined to the media. The experimental bacterial lesions of vessels simulate the endarteritis chronica deformans which develop the pearly intimal plaques.

RICHARD T. HEWLETT.

(To be continued.)

A GEORGIA INDEPENDENT SOCIETY.—The "Atlanta Constitution" is authority for the statement that a new State Medical Association is being formed through the efforts of a number of leading physicians of Georgia. The promotors insist that they are in no sense making a fight on the Georgia Medical Association, but objecting to some of the features of the American Medical Association they are forming a body in which they will be free to act for themselves.

MAKING COCAINE FIENDS.—William Jay Schieffelin, the wholesale druggist, declared at a hearing at Albany, that there were drug stores in New York City which gave away cocaine for the purpose of developing the habit and creating customers. He says that 20 per cent of the cocaine manufactured in this country is converted to illicit uses. His remarks suggest that the public is insufficiently protected against unscruppulos druggists.—Texas Med. News.

CLINICAL THERAPEUTICS

A forum of original experience, to which scientific contributions are invited. Responsibility for views promulgated imited to author.

VIOFORM—ITS USE IN OTOLOGY.

B. P. REKO, M. D.

CHICAGO.

Ear Department, Rush Medical College.

THIS but an attempt to record my experience with vioform as to its clinical aspect in otology. Its value in general surgical work has been extensively demonstrated by Tavel, Krecke, Schmieden, Wehrle and others. It has been recommended as a substitute for iodoform and, indeed, the chemical and bacteriological tests as well as the clinical investigations would undoubtedly confirm that opinion. Therefore I can restrict myself to a mere recapitulation of the acknowledged facts.

Vioform is a derivative of chinoline, whose antiseptic, antizymotic and antipyretic properties become still more prouounced by the introduction of one atom of iodine and chlorine. It is a grayish-yellow powder of great stability to light, heat and moisture. It is practically insoluble in water and, as it is much lighter than water, it forms a thin film on the surface. Compared with iodoform, it possesses the following advantages:

1. Its bactericidal power is greater than that of iodoform, whose styptic, deodorizing and infection preventing action it retains.
2. It is non-irritant, being neutral and therefore non-caustic.
3. It is non-toxic.
4. It is stable and readily sterilized without decomposition.
5. It is practically odorless.

Its only disavantage is that it cannot be used for subcutaneous injections, since abscess formation is liable to occur.

My attention was first directed to this preparation at the Ear Clinic of Prof. Politzer in Vienna, and afterwards in the Austrian army, where vioform has been adopted for use.

My intentions were to keep record of the effects of this remedy in cases of middle-ear suppuration, based on the rhodan kali (potassium sulphocyanide) test of the saliva.

Prior observations at the clinic of Prof. Politzer led me to ascribe great value to this test in diseases of the middle-ear, since absence or only traces of rhodan kali (potassium sulphocyanide)—KCNS—in the saliva suggests a disease of the middle-ear with lesion of

Vide: Alexander & Reko: "Beitrag zur Verwertung der Rhodanprobe des Speichels bei Ohrenerkrankungen." Wiener Klinische Wochenschrift, 1902, No. 42.

the tympanic plexus, while the reappearance or increased amount of rhodan kali (potassium sulphocyanide) during the course of the disease would indicate a favorable progress.

Where bilateral suppuration permitted a more critical comparison of the different antiseptics en vogue, I improved the opportunity to test the superiority of vioform over jodol, airol and dermatol. In all observed cases vioform acted as an ideal antiseptic and siccative, hastening the reappearance of the rhodan kali (potassium sulphocyanide) in the cases where a cure was performed. In acute suppuration I found it of better advantage to follow the dry treatment and use boric acid for the first days after perforation, as it readily dissolves in the secretion, and does not easily interfere with drainage. The after-treatment consisting of the use of vioform as dusting powder finished the process of resorption speedily. Of special interest to me were cases of radical operation, where I could observe, whether or not vioform would shorten the time of recovery, which in uncomplicated cases amounts to about four weeks, as indicated by the typical reappearance of the rhodan kali (potassium sulphocyanide) at that time in all our observed cases (fifteen) at the Ear Clinic of Prof. Politzer. Unfortunately my observations in this direction were limited to a single case of radical operation during the time of this investigation, but in this case the decided favorable action of vioform on the course of the healing process was very much pronounced. The granulations were clean and small, and the restoration was performed in two weeks, as shown by the rhodan kali (potassium sulphocyanide) test. Similar results were obtained by Lindt and Siebenmann, who use vioform exclusively. Lindt observed that vioform does not tend to favor abnormally marked granulations, and does not harm epithelial growth in the exposed middle-ear cavities after radical operations.

Siebenmann found that wounds after radical operations were repaired quicker than by airol or dermatol. "Vioform is recommendable for after-treatment in radical operation, as it excites less granulations than under the application of iodoform, and the new formation of epithelium progresses quicker therefore."

My observations are not limited to the use of vioform in otological cases. I use vioform very extensively in my private practice after operations in the nose, where tampons of vioform gauze may be left for days without becoming malodorous owing to decomposition. From my observations I am led to the conviction that vioform deserves first rank among the antiseptics in use in rhino-laryngology.

MEDICAL MISCELLANY

Juglans is a good vermifuge and it is claimed that it has destroyed tape-worms.

MORTALITY FROM HOMICIDE AND VIOLENCE.—The number of homicides and deaths by violence in the United States in 1905 was 9,212, as against 8,482 in 1904. Suicides, 9,082, as against 9,240 in 1904. Killed on steam railroads, in 1905, 3,142; injured, 15,904. Killed on electric and elevated railroads, 464; injured, 2,622. These statistics, collected by the Chicago Tribune, are unofficial, but perhaps they are none the less trustworthy on that account. We murder and manslaughter nine times as many as the Germans; four times as many as the English, Scotch and Welsh. America seems to be a little careless, to put it mildly.

THE KLEPTOMANIAC.—"A New York specialist got, on a certain morning, the card of one of the richest of our Western millionaires. He went down instantly and found a well-dressed man, who said:

"'I am here, sir, on a delicate and painful matter. My wife is a victim of kleptomania, and, knowing your skill in mental diseases, I have brought her on for treatment under you.'

"'Bring the lady to see me tomorrow morning,' said the physician.

"'It will be best not to bring her to your office,' faltered the millionaire. 'The sight of other patients might excite her. I suggest——'

"'I'll receive her in my drawing-room. Will that be better?' asked the physician.

"'Oh, much better,' said the other, in a relieved tone.

"And the next day the Western millionaire led into the physician's drawing-room a young woman of singular beauty. She was magnificently dressed, but her eyes were furitive and restless, and when she thought no one was looking at her, she secreted under her coat three or four valuable ornaments. The physician and the Westerner smiled slightly at one another.

"The physician, after his examination of the patient, told the husband to return the next day alone.

"'And when I come,' the husband answered, 'I'll bring back these things that she has taken.'

"'Do,' said the said the physician.

"'I will,' said the Westerner.

"But he didn't. He won't. He and his wife are thieves, and they have worked their kleptomania dodge in nearly every city in America."

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A Cosmopolitan Biweekly for the General Practitioner

The Medical Fortnightly is devoted to the progress of the Practice and Science of Medicine and Surgery. Its aim is to present topics of interest and importance to physicians, and to this end, in addition to a well-selected corps of Department Editors, it has secured correspondents in the leading medical centers of Europe and America. Contributions of a scientific nature, and original in character, solicited. News of Societies, and of interesting medical topics, cordially invited.

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SEASONABLE THERAPEUTICS

APPLICATION FOR PAINFUL AND BLEEDING HEMORRHOIDS.—

Stovaine	7 grs.
Adrenalin, 1 to 1,000	1 drm.
Water	6 drms.

Moisten a tampon of cotton, apply to the painful part, and cover with a piece of rubber dam.

Or the following suppository may be used:

Stovaine	1 gr.
Orthoform	1½ grs.
Adrenalin solution, 1 to 1,000.	4 drops
Extract belladonna	¼ gr.
Coca butter	45 grs.

Make into a suppository.—La Presse Medicale Belge.

DIARRHEA IN INFANCY.—The following combinations are recommended by Yeo in the treatment of diarrheas occurring in infancy:

Sodii bicarb	gr. iv
Pulv. rhei	gr. iss
Pulv. cinnamomi	gr. i

M. Ft. chart. No. i.

One such powder to be taken twice a day.

When curds of milk are present in the stools the following combination is recommended:

Pulv. ipecac. et opii	gr. xv
Pulv. guaranae	gr. ¾
Pulv. sacchari albi	gr. xlv

M. Ft. chart. No. x.

One powder every two or three hours.

In cases of profuse diarrhea without dyspeptic symptoms, the following combination is recommended:

Tinct. krameriae	ʒ ss
Tinct opii	m. iss
Syr. simplicis	ʒ iiss
Aquae destil	ʒ iii

One dessertspoonful every two hours.

In cases in which anemia is a factor following chronic diarrhea, the following combination is of service:

Ferri carb. sacch	
Pulv. ipecac. et opii	aa gr. iss

M. Ft. chart. No. x.

Three or four powders daily.

In cases of fetid diarrhea, in which there is marked evidence of putrefaction with foul odor, the following is recommended:

Ferri sulphatis	
Sodii salicylatis	aa gr. xx
Glycerini	ʒ iii
Aquae	ʒ iii

Dissolve the sulphate of iron and the salicylate of soda separately and then mix. One tablespoonful every three hours until the stools are blackened.

In summer diarrhea, the following is of value:

Decoct. hematoxyli (5%)	
Acidi sulphurici arom	aa ʒ ii
Spiritus chloroformi	ʒ vi
Tinct. opii camph	
Tinct. card. comp	aa ʒ i

One teaspoonful in water after each movement of the bowels.

In cases of ulcerative colitis, Yeo recommends the following combination as a rectal injection:

Argenti nitratis	ʒ ss-i
Aquae dest	Oi-ii

Elevate the hips and allow the water to flow in slowly from a siphon bag.—Merck's Archiv.

A CONSCIENTIOUS PATIENT.—"Medicine won't help you any," the doctor told his patient. "What you need is a complete change of living. Get away to some quiet country place for a month. Go to bed early, eat more roast beef, drink plenty of good, rich milk and smoke just one cigar a day."

A month later the patient walked into the doctor's office. He looked like a new man, and the doctor told him so.

"Yes, doctor, your advice certainly did the business. I went to bed early and did all the other things you told me. But, say, doctor, that one cigar a day almost killed me at first. It's no joke starting in to smoke at my time of life."—Everybody's Magazine.

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MEDICAL MEMORANDA.

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Constipation.—No condition is more prevalent, especially among persons leading sedentary lives than difficulty and irregularity of defecation. The causes of this are many, most of them being the results of advanced civilization; but since most constipated persons will not faithfully follow a plan calculated to remove the primary cause, it devolves upon the medical attendant to outline a treatment that will, in a measure, neutralize the condition existing. In all these cases, there is a sluggish state almost approaching paralysis. For this purpose, pill cascara cathartic (Hinkle), made by Warner & Co., is not excelled. It increases peristalsis and overcomes hepatic inactivity. In these cases, it is most important that particular attention be paid to the liver, for if this organ does not functionate properly, the bowels will not be restored to a normal state. One or two pills may be ordered as the condition demands, and as improvement follows, the interval between doses may be lengthened.

Sold Only to the Profession.—We are great believers in consistency and when we find a firm selling an article advertised "Sold only to Physicians" lives up to its word, we believe in commending them. An abstract is given from a letter written to an inquirer in Conneticut, which greatly pleased the local physician.

153 So. Jefferson St,
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Ecthol is an agent that is gaining great popularity by reason of its wide range of usefulness. It contains the active principle of echinacea, which is an old remedy. A recent number of the Chicago Year Book states that the prompt results gained from it have caused all writers to express themselves with such apparent extravagance as to really retard the introduction of this agent to the profession at large. In summing up, the statement is made, that "it will yet establish for itself, by its inherent valuable therapeutic properties, with the entire profession a fixed and permanent place." Ecthol is anti-purulent and a corrector of all dyscrasia of the fluids. It is used locally and internally. The dose is a teaspoonful four to eight times daily. It is useful in septicemia and all cases of blood poisoning from whatsoever cause. It is excellent for erysipelas, carbuncles, abscesses, boils, sores, ulcers, gangrene and as a gargle in diphtheria and putrid sore throat.—W.T. Marrs M. D.. in the Medical Summary.

Conservative Surgery, or the Use of External Applications in Cases of Doubtful Surgical Procedure.—(By F. W. Hander, M. D., Beaumont, Texas.)—Without any comment on the conservation with which a surgeon should use the knife in doubtful surgical cases as regards time, symptoms and condition of patient, I shall give you several cases which have been under my observation: Mrs. H., aged 24, married, had suffered pain in both ovaries, especially the right, shortly before, during and for a short time after menstruation, from the beginning of her menstrual life at the age of 14. This pain gradually increased in severity and time of duration until it had become almost constant and unbearable. After being advised by several excellent physicians to undergo operative procedure for diagnostic as well as curative purposes, she consented. When the abdomen was opened both ovaries were found to be cystic, the cysts being more numerous in the right. The appendix was normal and healthy and gave no evidence of having been in a pathological condition at any previous time. Both ovaries were removed as a curative and preventative measure. The patient made an uneventful recovery from the operation, but for three years after, when she again sought medical advice, the pain continued as before, with the addition of slight swelling and tension in the right hypochondriac region. The patient passed through the artificial menopause with very little inconvenience or nervous disturbance. Case 2.—Man, married, age about 27, suffering from acute attack of appendicitis, as diagnosed by the attending physician, two consulting physicians concurring. Constitutional symptoms present and anatomical appearances, such as tension, redness, swelling and pain at McBurney's point, pronounced. Operation advised, to which patient and wife objected. In the above cases antiphlogistine was repeatedly applied, with the most marked benefit. In case one, although the woman had suffered three years after the operation, through the influence of antiphlogistine, the pain and tension were modified, leaving only a small, soft elevation in the region of the appendix. Pain returned

only at long intervals and with diminishing severity, and there is every indication now, after one year's treatment along this line, of permanent relief. In case two the same treatment was carried out. Tension, redness, swelling and pain diminished with the first application of antiphlogistine, and disappeared after ten days. With some constitutional treatment the patient entirely recovered in this time. In this case there has been no recurrence of the attack in three years. I had another case in which two wire nails were driven through the palm by a falling timber. This was followed by pain and swelling after a few hours (no bleeding), the swelling extending up the forearm. Another case was a deep infected wound following paronychia. This wound was opened to the bone and free drainage established. but it gradually grew worse, involving the whole hand. Amputation of the finger or hand was advised, to which the patient objected, saying he would die first. In both these cases the local application of phenol and antiphlogistine gave relief and finally cure. In the latter case I cleansed the wound with hydrogen peroxide and applied silver nitrate to the exuberant granulations. Multiplies of these minor cases could be given, where the knife was seemingly indicated, but which rapidly yielded to local applications along the above lines. I also had an interesting case in a boy 12 years of age who suffered from osteo-myelitis of the femur of several years' standing. The discharge was constant through a fistular opening, and the case showed no evidence of improvement, although at several operations all diseased bone and some healthy bone had been removed. Antiphlogistine dressing was persistently applied, with the result that several large particles of bone sloughed off, after which the opening rapidly closed. No further pathological process has been observed in this case in ten years, although an enlarged knee joint and some ankylosis remain as sequelae.

The Rationale of the Use of Iron in the Treatment of Phthisis.—It is singular, yet significant, fact, with the exception of a single disease, there is always a slight diversity of opinion among physicians as to which one of a number of agents exercises the greatest curative influence upon a given disorder. The one exception is phthisis. The entire profession is united in the conviction that pure air, more than any one factor, exerts a controlling influence upon the development of phthisical manifestations. Indeed, physicians concur in the opinion that, with the proper quality and quantity of atmosphere, this most widespread and fatal of all human maladies can oftentimes be cured. While the beneficial influences of climate upon phthisical individuals has long been recognized by the profession, a perfect understanding of the exact manner in which atmosphere arrests the progress of the disease is a comparatively recent acquisition. The opinion at one time obtained that mountainous and elevated districts were beneficial to phthisical subjects on account of the elevation alone. Recent investigations have disproved this theory. It is now an accepted fact that elevation, per se, is of little or no importance. On the contrary, the seashore is ofttimes better adapted to phthisical individuals than regions of a much higher altitude. While it is true that the higher altitude, the less prevalent is phthisis, the explanation is that atmospheric impurities are less abundant and ozone is more plenteous in such regions than elsewhere. In other words, it is conceded that the absence of atmospheric impurities and the presence of ozone are the chief elements in the cure of phthisis, and that any section, high or low, which affords these elements is advantageous to the phthisical individual. The benefit derived by consumptives from living in or near pine forests, is a matter of common observation. The turpentine exhaled from pine trees converts oxygen into ozone, and the atmosphere is thus purified by the process of oxidation. Having repeatedly proved that the direct inhalation of ozone is of little, if any, benefit, we are forced to the conclusion that it is not ozone which arrests the progress of phthisis, but the systemic oxidation which is brought to the maximum by the inhalation of a perfectly pure atmosphere. In fine, we are now agreed that if systemic oxidation can, in any manner, be maintained at the proper standard of activity without exhausting the vital forces of the subject, the progress of phthisis can be checked, and very frequently completely cured. Although the benefits derivable by phthisical individuals from an atmosphere that is conducive to a full measure of systemic oxidation are immeasurably great, the fact remains that it is not always within the power of the physician to induce the patient to move to a region affording such an atmosphere. The patient may, through inability to pursue his vocation, be financially unable to make a change of residence, or he may be influenced by the optimism peculiar to phthisical subjects, to postpone the change until the disease has progressed too far. When, for any reason whatever, it is not possible to change the abode of these subjects, it is within the power of the physician to check the progress of the disease by the augmentation of systemic oxidation. While all forms of iron increase systemic oxidation by converting the oxygen in the economy into ozone, the mucous surface of the alimentary tract of phthisical subjects is usually too enfeebled to absorb iron unless it is presented in the organo-plastic form. For this reason, pepto-mangan (Gude) affords results which cannot possibly be secured from any other preparation of iron. In addition to promoting oxidation to a surprising degree, pepto-mangan (Gude) invigorates the digestive functions and increases the nutritive processes most markedly. The appetite of the patient is improved, the wasting is arrested,and the vital forces are greatly enlarged by the continued employment of the preparation.